



Washington State Department of
Health Public Health Laboratories

PUBLIC HEALTH LABORATORIES
CLIA #50D0661453
1610 N.E. 150th Street MS: K17-9
P.O. BOX 550501
Shoreline, WA 98155-9701
Ph. (206) 418-5622 / Fx. (206) 418-5485

Lab Number

Date Received

Shaded Area for DOH Lab Use Only

Syphilis Serology

Please Print Clearly.

MAIL RESULTS

To:	SUBMITTER ADDRESS	
	SUBMITTER PHONE WITH AREA CODE	COUNTY

DESCRIPTION OF SPECIMEN

- ☐ **Serum** (suitable specimen for VDRL and/or TPPA)
- ☐ **Spinal Fluid** (suitable specimen for VDRL only)

Collection Date (Mo/Day/Year)

Time Collected

PATIENT IDENTIFICATION

NAME (LAST)	(FIRST)	(MIDDLE)	Gender Female Male	Date of Birth (Mo/Day/Year)
HOME ADDRESS				Patient ID Number
CITY	STATE	ZIP CODE	Ordering Physician	

REASON FOR TEST

☐ **Treatment Control**
(VDRL only, Syphilis already confirmed)

☐ **Prenatal**
(Screen due to pregnancy)

☐ **Premarital State:** _____
(Required for Marriage License)

☐ **Diagnostic / Screen**
(VDRL as screen, if reactive TPPA will be performed for confirmation)

☐ **Reference**
(VDRL and TPPA performed, Clinical history indicative of Syphilis)

SYMPTOMS

☐ **NO** ☐ **YES** _____

(If yes, list symptoms. If symptoms indicative of syphilis, please check REFERENCE)

PREVIOUS TEST RESULT: (Please list any previous test results pertaining to specimen submission)

☐ **VDRL** _____ ☐ **RPR** _____ ☐ **OTHER** _____

COMMENTS: (Any Additional Information)

Red or highlighted information is required.
Filling out the form correctly will ensure prompt results.
Thank you for your cooperation.

DOH 303-606 (Rev. 1/26/05)